A monthly public policy newsletter from the
Mental Health Association in Michigan (MHAM) | Vol. 2 No. 8

More on Lakeshore & the State Mental Health System

The situation with Lakeshore Regional Entity (LRE) – see last issue – is in some flux as LRE has asked for a state administrative appeal hearing and filed a lawsuit, only to withdraw the suit for now.

Meanwhile, a number of leading advocacy groups have developed a paper on the Lakeshore situation and the state as a whole. The report has been divided into two parts. The first, primarily on immediate next steps for the Lakeshore region (if and when it's terminated), was released Aug. 5th and is reprinted here. Part 2, on the state as a whole, will be released shortly and appear in our next issue. The seven authoring groups are: The Arc – Michigan; Association for Children's Mental Health; Mental Health Association in Michighan; Michigan Developmental Disability Council; Michigan Disability Rights Coalition; Michigan Protection & Advocacy; and NAMI – Michigan.

Here is Part 1 of the report:

Introduction

Michigan's publicly funded mental health system is in crisis. Among the reasons are the system's poor structure and organization, an overly complicated bureaucracy, and lack of funding.

The recent announcement from MDHHS that it intends to terminate the PIHP contract for Lakeshore Regional Entity (LRE) has sparked a new controversy in the mental health arena. This comes on top of the very controversial decision by a majority in the Legislature that Michigan should test certain new models of integrating behavioral and other health care appropriations ("Section 298").

The mental health advocacy community believes it is time for meaningful solutions to some critical problems. In this, the first of two installments to be issued in August, we focus on immediate next steps to deal with the situation in the Lakeshore region. The second installment of our report will deal with changes that are needed statewide to advance mental health services and supports in Michigan.

Our overarching objective is to improve service availability, accessibility, and involvement for consumers in need, irrespective of turf battles, profit margins, and protecting anyone's place within the bureaucracy.

Looking at Lakeshore

LRE is one of ten Prepaid Inpatient Health Plans (PIHPs) that have existed in Michigan for several years. These entities serve as intermediaries between MDDHS and local service delivery CMHSPs when it comes to Medicaid specialty behavioral health.

Current law permits MDHHS to terminate the contract of a poorly performing PIHP. LRE has certainly been that, constantly entering financial difficulty and showing its management inability by having to turn to an outside entity (Beacon Options) for assistance in its day-to-day work, thus siphoning even more money from services. (All PIHPs siphon money away from direct services and supports.) The advocacy community has found LRE to be deficient in person-centered planning, family-driven/youth-guided policies/practices, and consumer self-determination (problems to varying degrees across all PIHPs), as well as several important Medicaid mental health service-and-support procedures and practices.

Why has LRE failed? There are two predominant reasons:

(1) Michigan has set up an incredible conflict-of-interest situation regarding PIHPs and CMHSPs. PIHPs are to be established, organized, and governed by CMHSPs, yet the PIHPs are then expected to regulate

member CMHSPs regarding Medicaid specialty behavioral care. This is an unworkable long-term situation, and produced in Lakeshore a phenomenon where the PIHP could not control its member CMHSP "bosses."

(2) Mental health is and had been under-funded in Michigan, for both Medicaid and non-Medicaid services. The advent of Healthy Michigan Medicaid expansion brought a catastrophic reduction in non-Medicaid appropriations to CMHSPs, and the state has yet to find an effective funding formula for Medicaid mental health disbursement. Our public mental health system has also been given increased responsibilities without concomitant funding increases. This contributed to LRE's long-standing financial problems, as well as similar problems more recently experienced by most of the state's PIHPs.

In our coming second installment of this report, we will address statewide recommendations for system reorganization and funding.

Given the MDHHS decision on Lakeshore, which we support, what should now happen in the Lakeshore region, pending any termination appeal or other legal action from LRE?

MDHHS should place the affected region under temporary receivership, and use temporary outside assistance in managing the region. MDHHS is taking these steps with Lakeshore. The department will in effect be the PIHP, and will use Beacon Options for outside assistance, just as LRE was already doing. MDHHS has also said it will appoint a replacement board for the region.

How long should "temporary" be? MDHHS apparently perceives that as potentially lasting all of FY-20, with the Department then promising a new, non-temporary PIHP and Board. **Whatever the temporary period is, MDHHS should publish the steps involved in moving to permanence, with a timetable for each step.**

Who should sit on the temporary regional board? MDHHS has proposed the following:

*5 members from the region's CMHSPs

*1 representative of county governments in the region

*1 individual (or family member of) receiving services from the PIHP

*1 member of an advocacy group representing individuals with behavioral health needs or developmental/intellectual disabilities

*3 representatives of MDHHS

*3 individuals with expertise in behavioral health or developmental/intellectual disability services and/or administration

* 1 representative of "the contracted PIHP" (presumably meaning Beacon Options)

We disagree with the specifics of the MDHHS proposal on Board representation from CMHSPs and consumers/families.
Any Board members from regional CMHSPs should be ex-officio only. To do otherwise continues the very misguided notion that CMHSPs which are to be regulated by PIHPs should have some degree of control over a PIHP.

Further, MDHHS has been far too restrictive in the consumer/family category. At least one-third of the new board should be service consumers or their family members, with at least half the consumer/family members being direct service consumers. This is consistent with the requirements for CMHSP board

service, and it was recommended by the MDHHS Section 298 Workgroup in 2017 (and that body's precursor – the Section 298 task force convened by Lt. Governor Calley). It is illogical to expect decisions in the best interests of consumers/families (including families with minor children/youth who need service) if there are virtually no consumers/families represented on the board.

How should public transparency and accountability be fostered?

The department has stated the new temporary board will be subject to Open Meetings and FOIA laws. **We commend and strongly support the department's approach on this. We would also add that there must be thorough vetting of potential voting board members for possible conflicts-of-interest they may bring to the table.**

In a time of uncertainty and stress as steps occur in the temporary Lakeshore region, what mechanisms should be in place for consumer protection?

The department has stated the Lakeshore region will have an independent service review committee, comprised of practitioners, to conduct consumer-requested reviews of adverse benefit decisions. The committee would have binding power to make decisions about a consumer-initiated case complaint. **We commend and support this step, but it needs to define "practitioners." It also needs to define "independent," as the committee members should not be connected to MDHHS, Beacon Options, any CMHSPs, or the CMHSP provider networks.**

There is also more needed for consumer protection, and we recommend:

***A freeze of at least 90 days should be put on service reductions within the region, excluding clinically warranted and documented step-downs from hospitalization.**

***A similar freeze should be placed on the array of existing services, and on service array determination methods, within the region.**

***Increased involvement of the MDHHS Recipient Rights Office should occur in monitoring protection of consumer rights across the region.**

Finally, **Next steps in Lakeshore cannot become a back-door attempt to implement what the Legislature called for in Budget Section 298.** We will discuss this further in the coming Part Two of our report.

<u>Closing Comments</u>

This initial installment of our report has focused primarily on the situation in the Lakeshore region and the immediate steps that are or should be taken there. We support the MDHHS decision for contract termination. We also support a number of the temporary steps proposed for the region by the department, but also believe some of those steps need modification, along with the addition of some new ones. Our biggest disappointment involves who would/won't be eligible for service on the new temporary PIHP board.

In the next installment of our report – coming shortly – we will look at the state as a whole and offer recommendations for alleviating a mental health system in crisis.

<u>Caro Psychiatric Hospital – What Happens There Misses the Big Picture</u>

MDHHS has announced its intent regarding the state psychiatric hospital in Caro.

Governor Snyder and the Legislature had an agreement to close down the existing Caro facility and replace it with a new 200-bed psychiatric hospital in Caro. MDHHS balked at that and brought in a consulting group

for advice. Upon receiving the consultant report, MDHHS announced its desire to replace the 200 beds that would have been created at a "new" Caro as follows:

*"Old" Caro would remain with 84 beds.

*Re-opened units elsewhere in the state-operated psych hospital system would create 61 beds.

*55 slots would be created for special community service without hospitalization.

We don't yet know if the Governor will sign onto this, or what the Legislature will do if she does.

But the precise future of Caro pales in comparison to a much bigger problem with state-operated psychiatric hospital beds.

Michigan has a severe shortage of state-operated psychiatric hospital beds. This is a major reason our mental health system is in crisis, and why some of our most severe mental illness cases cycle repeatedly into difficulty, including justice system incarceration, homelessness, and early mortality. Did you know persons with serious mental illness live 25 years less than the population-at-large?

We only have three state-operated hospitals left for adults, and just one for children. The Treatment Advocacy Center (Virginia) says we're one of the nation's five worst states when it comes to per capita state-operated psychiatric hospital beds. And that's just part of the problem.

Because demand is above capacity at the state's Forensic Center (involving psychiatric assessment, treatment, and housing of some criminal cases), our three adult psychiatric hospitals are at least half-filled with forensic inpatients, with a lengthy waiting list existing for admissions.

For decades, as Michigan closed most state-operated psychiatric hospitals, the state has relied on private psychiatric hospitals and psychiatric units in community hospitals for inpatient care. That has been misguided. We have 27% less such beds than we did 25 years ago; these hospitals often don't want inpatients with combative behaviors or histories; and the average length-of-stay in such facilities is less than a week, something MHAM documented in a survey five years ago. For most persons with active symptoms of severe mental illness, less than a week in a hospital is not enough time for appropriate stabilization. Rather, we heavily medicate inpatients and then send them on their way, with or without links to step-down community service. And too often, the medications that were given in the hospital are ignored and discarded.

Michigan presently has around 750 state-operated psychiatric hospital beds. Twenty years ago, when we had about 960 and the federal government reported we used such beds at less than half the national average, major statewide advocacy and professional groups concluded that Michigan needed at least 400 more such beds, split evenly for adults and children. Using that criterion, we need 600 more today.

State-operated psychiatric beds are the only ones where someone can get an intermediate-length or longer-term stay. This was partly recognized in 2013 by Lt. Governor Calley's Mental Health and Wellness Commission, when it recommended: "Authorize intermediate care beds for both juveniles and adults with a mental illness. Care beds should be made available on a regional basis for stay periods (up) to 30 days and incorporate substance and alcohol use disorder as well as mental health issues."

Without intermediate and longer stays available, we continually shuttle people in and out of short hospital stays (or none at all) without any long-term improvement and stability.

Most people with mental illness don't need hospitalization. And we don't want anyone in a psychiatric hospital if it's not needed. But for some of the most severe cases, our current scientific limits leave no other recourse at times. To continually shuttle those cases in and out of short-term hospital stays is cruel, unproductive, and a major cost to society.

Are we so deficient on hospital beds compared to the rest of the country because our community care system is so outstanding and superior to everyone else's? The answer is a resounding No. And, some of our constituents at certain points in their lives cannot benefit from non-hospital care.

This is the elephant in the room that most people don't want to acknowledge. But our mental health system will remain in crisis if we don't. Yes, it will cost money. If we aren't willing to prioritize more funding for something as critical as this, what kind of a state are we?

Trump Talks of Mental Illness for Political Purposes

President Trump's main answer for gun violence and mass shootings in America appears to be mental illness. Ever since the latest mass shootings, he has continually bemoaned what a "big problem" we have with mental health relative to gun violence. More recently, he has been referencing the lack of "institutional care" for mental illness as a major gun violence factor.

Here is a summary of related research from the Treatment Advocacy Center (TAC):

1. Most people with serious mental illness are not dangerous.

2. Most acts of violence are committed by individuals who don't have mental illness.

3. Those with serious mental illness are victimized by violent acts more often than they commit them.

4. Being a young male or someone who abuses alcohol or other drugs is a greater risk factor for violent behavior than having mental illness.

5. No evidence suggests that people with serious mental illness receiving effective treatment are more dangerous than the general population.

6. That being said, a small numbewr of individuals with serious mental illness do commit acts of violence. Persons who are not being treated commit almost all of these acts; many of them are also abusing alcohol or other drugs.

What about serious mental illness and mass killings? TAC wrote in 2018:

Studies of mass killings strongly suggest they began to increase in incidence in the 1980s, and that the incidence is (still) increasing. The most comprehensive survey of mass homicides in the 20th century reported 73 such killings from 1990 to 1999. In 2017, nearly one incident meeting the federal government's definition of 'mass shooting' occurred each day. As to the percentage of mass homicides in which the perpetrator had an untreated serious mental illness, the answer varies based on how serious mental illness and mass killings are defined, the time period covered, and other factors. In general, however, it appears that at least one-third of mass killings are carried out by individuals with untreated serious mental illness, even when narrowly defined (e.g., psychosis).

What to make of the above, if it is accurate?

Mental illness is a very small factor in the commission of violent acts. There are other factors that better predict if a violent act might occur. Regarding mass killings, untreated serious mental illness is regrettably

one of several factors that may have some import. But we're talking about an infintesimally small number of people. How do you find these needles in the haystack? Will stronger background checks be a guarantee? "Red flag" laws (which have been introduced in Michigan but never acted upon)? Dramatically increasing institutional care? The answer to each of these is No, there isn't a guarantee that they find the needle in the haystack. Meanwhile, we trample civil liberties and risk unwarranted hospitalizations in the quest for that needle.

President Trump is right that we have a "big problem" with mental health, but not in the way he meant it. We continue to sigmatize mental health, and do a poor job of finding and treating it. We have let thousands upon thousands suffer because we aren't willing to do more.

And we doubt the President understands we haven't de-institutionalized. Rather, we've trans-institutionalized with the national epidemic of mental illness in jails, prisons, and juvenile justice facilities. While there are legitimate reasons to question the unavailability and inaccessibility of psychiatric inpatient care (see above), gun violence is not such a reason.

This country has too many people with too many guns, including weapons that facilitate mass murder. There are people from all walks of life, including some with mental illness and many without it, who have no business possessing automatic and semi-automatic weapons. That is our number one problem regarding gun violence. Decrying mental illness won't fix it. But that appears to matter not to the President.